AFFIDAVIT OF COMPLETION
PHARMACY TECHNICIAN TRAINING AND EDUCATION PROGRAM

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Phone: 317-234-2067
Fax: 317-233-4236
Web: www.bop.IN.gov

QUALIFYING PHARMACIST STATEMENT AND AFFIDAVIT

I, _____, do solemnly swear or affirm, under the penalties of perjury,
(*Name of qualifying pharmacist*)

that _____ began the following Indiana Board of Pharmacy approved
(*Name of pharmacy technician applicant*)

training and education program, _____ ,
(*Name of the Indiana Board of Pharmacy approved program completed*)

on _____ and successfully completed training on _____.
(Start date) (*Completion date*)

Signature of Qualifying Pharmacist	License Number
Name of Pharmacy	Pharmacy Permit Number
Date	

APPLICANT AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this affidavit are true, complete, and correct.

Signature of Pharmacy Technician Applicant	Technician-in-Training Permit Number*, if applicable*
Date	